

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1803</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/13/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WYNDRIDGE HEALTH AND REHAB CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>456 WAYNE AVENUE</b> <b>CROSSVILLE, TN 38555</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: Census: 91</p> <p>A Life Safety Code Complaint Investigation of TN00055203 was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 9/13/2021. During this Life Safety Code Complaint Investigation, Wyndridge Health and Rehab was found in substantial compliance with the requirements of the Tennessee Rules and Regulations 1200-08-06, Standards for Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).</p>	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE